Patient Registration

Please Print Clearly INFO HOME: ☐ Yes ☐ No

Date:_____ Name: _____ Age: _____
Last First Initial

SSN(client): _____ DOB: _____

Mailing Address: _____ Ok to mail? Yes ☐ No ☐
Street/PO Box City State Zip

Phone (home): _____ Ok to leave message ☐ Yes ☐ No _____

other (specify): _____ Ok to leave message ☐ Yes ☐ No _____

Emergency Contact/Relationship: _____ Phone: _____

Please check BOTH Race and Ethnicity

RACE: White ☐ Black/ African American ☐ American Indian/ Alaska Native ☐ Asian ☐ Hawaiian/ Pacific Islander ☐

ETHNICITY: Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐

Household members including yourself Total Number in household:_____

Name _____ Relationship to patient _____ Date of Birth _____
Name _____ Relationship to patient _____ Date of Birth _____
Name _____ Relationship to patient _____ Date of Birth _____
Name _____ Relationship to patient _____ Date of Birth _____
Name _____ Relationship to patient _____ Date of Birth _____

For additional family members or other additional information, please use the back of this form

INCOME INFORMATION MUST BE COMPLETED

Employment: Client ☐ Yes ☐ No Spouse/Other ☐ Yes ☐ No

If yes complete the following:

Employer _____ Address _____ Phone _____ Gross Monthly $ _____

Spouse/Other Employer _____ Address _____ Phone _____ Gross Monthly $ _____

Income Verified with: ☐ Check stub ☐ Tax Return ☐ Estimate/To Be Provided ☐ None

Other Income Sources:

SSI ☐ $_____ Veteran's Benefits ☐ $_____ Unemployment Compensation ☐ $_____ Child Support ☐ $_____

Other (specify) ☐ _____ (i.e. alimony, TANF, General Assistance, rent, military allotments, etc.

Insurance: ☐ Yes ☐ No If yes, specify below and provide copy of insurance card:

☐ Medicaid ☐ MediCare ☐ Other/Private_____

✧ I voluntarily request the services provided by Ravalli County Public Health Nursing Services Family Planning Progra and give my consent to perform examinations, treatments, or diagnostic procedures deemed advisable or necessar

✧ I voluntarily request the services provided by Ravalli County Public Health Nursing Services Family Planning Progra I also assign my insurance benefits to be paid directly to Ravalli County Family Plannin
I understand that the financial information I have provided above will be used to determine my financ responsibility. I accept financial responsibility for any noncovered cost

Patient's Signature _____ Date _____

For Office Use Only

Date _____ % Pay ____	Date _____ % Pay _____	Date _____% Pay _____
Income Verified by: _____	Income Verified by: _____	Income Verified by: _____